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Reconfiguring Health Workforce Policy So That Education, Training, And Action Delivery of Care are Closely Connected

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ABSTRACT There is growing consensus that the health care workforce in the United States needs to be reconfigured to meet the needs of a health care system that is being rapidly and permanently redesigned.

Accountable care organizations and patient-centered medical homes, for instance, will greatly alter the mix of caregivers needed and create new roles for existing health care workers. The focus of health system innovation, however, has largely been on reorganizing care delivery processes, reengineering workflows, and adopting electronic technology to improve outcomes. Little attention has been paid to training workers to adapt to these systems and deliver patient care in ever more coordinated systems, such as integrated health care networks that harmonize primary care with acute inpatient and post-acute long-term care. This article highlights how neither regulatory policies nor market forces are keeping up with a rapidly changing delivery system and argues that training and education should be connected more closely to the actual delivery of care.

Overview

Health care professionals are being challenged to find new ways to organize care and develop systems that hold providers accountable for the quality, cost, and patient experience of care.¹ The once incremental pace of change is accelerating, and there is evidence that long-standing paradigms are dramatically shifting.² For example, the relatively slow acceptance of prepaid and managed care system is being replaced by the rapid adoption of bundled and risk-based payment models.^{3,4} Early adopters of accountable care organizations (ACOs) are finding that their workforce is shifting from acute care to community- and home-based settings with increasing roles for physicians, nurses, social workers, patient navigators and outreach coordinators, and other clinicians in providing enhanced care coordination, better medication management, and improved care transitions.⁵

The training of health professionals, however, lags behind these reforms because it remains largely insulated from change behind the walls of schools of medicine, dentistry, pharmacy, and nursing.

Medical training is done primarily in hospitals, while the greatest challenges are found in coordinating care in multiple outpatient settings. This article describes how health workforce policy was done in the past. It illustrates some of the specific changes under way and how they are changing the health care workforce. Further, it suggests that closer links should be built between the day-to-day caring for patients and the training of the people who deliver that care.

Teams and Workforce

Almost all of the new arrangements include plans or structures that call for more “team-based care” and make use of “enhanced” roles for various professions, despite a lack of consensus on what these two terms really mean. Teams have been described as groups of people whose roles continuously shift in response to internal and external forces, including patient expectations; policy and payment changes; organizational factors; geographic proximity of other providers; and professional regulation, training, and attitudes.^{12,13} Broadly conceptualized, roles within teams fall into two categories: lower-cost health professionals acting as substitutes for higher-cost ones (for example, nurse practitioners for physicians), or lower-cost health professionals functions as supplements who extend and enhance the work of others (for example, navigators to coordinate care or discharge planners to help patients make the transition from acute to post-acute care). Despite the numerous calls for more team-based models of care, relatively little attention has been given to how to prepare physicians, nurses, therapists, technicians, and others already in the workforce to practice in accountable or reformed teams.

Health care professionals have been seen more as parts of a puzzle that need to be carefully fit together into a transformed system of care than as fungible resources that can be crafted or remade to help build a truly reformed and more effective health care delivery system. For example, although the use of electronic health records (EHRs) has burgeoned with the implementations of the federal program to certify and reward the meaningful use of health information technology, there is limited understanding of how health professionals can work should be reconfigured and reallocated among team members. EHRs are shaping the work of clinicians as much as they are being adopted for and adapted to current practices. To be optimally effective, EHRs require broad and rapid adoption, practitioners must pay constant attention to data entry, and care patterns have to be reengineered to accommodate EHRs’ use.^{14,15}

Projecting Supply, Demand, Need, And Requirements

That workforce projections are controversial should come as no surprise; any projection will inevitably be ambushed by unknown or unexpected factors and events that affect future workforce supply and demand. The surprising thing is that projections, whether based on empirical models or “expert” opinion, are criticized for not correctly predicting the future when their purpose is almost always to change policies and practices. Projections, when accepted as roughly correct, are often followed by policy shifts that, in turn, change the future supply or pipeline of workforce production.

Projections turn out to be wrong either because it is not known how many physicians there are¹⁶ or because there is a lack of understanding of the true relationship between physician supply and health outcomes.¹⁷ They are, in one sense, “projectiles” shot across the bows of policy makers to stimulate action; they paint a picture of what is likely to happen if some desirable policy is not implemented. If a policy is changed, then the projection is likely to turn out wrong because it helped cause changes in

the factors that drove the model. For example, the Graduate Medical Education National Advisory Committee's 1980 projection of a physician surplus was used to justify cutbacks in federal support to medical education, thus changing medical school growth trends. That policy shift reduced production and eventually led to a perceived shortage.¹⁸ The more recent Association of American Medical Colleges forecasts of shortages of physicians have similarly prompted the expansion of existing and the opening of new medical schools and have put strong pressure on the debate over how to support graduate medical education to provide the additional training necessary to produce practicing physicians.¹⁹

Recent work has focused on developing dynamic projection models that are amenable to changes in the assumptions on which they are based and that allow policy makers to simulate the effects of potential policy scenarios²⁰ on workforce supply and demand. This type of work is supported by the National Center for Health Workforce Analysis in the Department of Health and Human Services, but the center struggles with a lack of both up-to-date inventories of existing health professionals and a common data set to measure practitioner capacity or simply identify the location of practice.^{21,22}

The modeling field in the United States and other countries²³ is moving toward using projections not as a method for generating one "right" answer but as a way to educate health professionals and their associations, policy makers, and other workforce stakeholders about the complexity of projecting future workforce needs and the effects of the policy options they have at hand. Engaging stakeholders—particularly clinicians—in the modeling process can generate numerous desirable results, including a better understanding of how rapid health system change affects workforce deployment and improved communication between the professions and policy makers. Having clinicians involved in modeling can also serve as a check on the "face validity" of model outputs and can generate clinical input in areas where data inputs are weak. Stakeholders engaged in modeling can also help identify ways to redesign care processes to address workforce shortfalls or surpluses. Models and projection thus cannot provide a single "right" answer in a system that is rapidly changing.

The important thing is to have a model that can be used to simulate the effect of policy change and educate stakeholders about the effects of policy options. For example, a model might show that increasing graduate medical education slots will likely have a relatively small effect on the overall match of supply to need compared to increasing productivity and delaying retirement. Efforts to model the nursing workforce have been complicated by nursing's persistent sinewave pattern of shortages prompting policy actions that, in turn, stimulate rapid growth leading to surpluses.²⁴ Analyses of nurse supply and demand remain doggedly unconnected to physician workforce projections.

There are no examples of national models that simultaneously project the supply of both professions despite their substantial overlap in providing care. Combining the two in projections is now an imperative, given nurses' complementary and supplementary roles in delivering or supporting many of the new services required by ACOs and patient-centered medical homes, such as care coordination, patient navigation, transition care, and population health management.

An obvious link would be in the production and deployment of nurse practitioners and their impact

on the “effective supply” of primary care practitioners,^{25,26} but including “nonphysicians” in physician supply-demand calculations has proved difficult. For example, in the development of an index to identify shortage areas for federal support, an intense battle was fought in a special “negotiated rulemaking” committee mandated by the Affordable Care Act over how to count nurse practitioners and physician assistants in a formula for proposed new Health Professional Shortage Areas and Medically Underserved Populations.²⁷ Advocates from the nurse practitioner and physician assistant professions felt strongly that they should be assigned a weight of at least 0.75 full-time-equivalent of a primary care physician to account for their contribution to community-based primary care. Counting them would often increase the local supply above a shortage threshold, making the community or population lose its designation and thus its eligibility for federal support.

(For full article, please see the SC IMPH website link here:

<http://imph.org/taskforces/workforce-health/>)

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